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Successful Community Re-entry for Older adults with Serious Mental Illness

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Outline of the Presentation

- **Describe older adults with serious mental illness**
  - Epidemiology, illness trajectory, treatment
- **Parole considerations**
  - The lived experience of older adults with schizophrenia transitioning to the community
  - Factors that contribute to successful community living
- **Best practices for CDCR partnering with community groups**
- **Questions and Discussion**

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Serious Mental Illness

- Clinically, we use SMI as an umbrella term for diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and anxiety disorders. These disorders differ in clinical course and severity. My talk today will focus mainly on schizophrenia.

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Epidemiology

- **Numbers of adults with SMI in Prison**
  - In a Bureau of Justice Statistics Special Report, it was determined that 56 percent of state inmates and 45 percent of federal inmates experienced a mental health problem (James and Glaze, 2004).
- **In the community**
  - Estimated 9.8 million adults aged 18 or older in the United States with SMI. This number represents 4.0% of all U.S. adults (SAMHSA).
  - The number of people with schizophrenia over 55 years of age will double, reaching 1.1 million by 2025. This number represents **one quarter of all people with schizophrenia** (Cohen et al., 2008).

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Schizophrenia Definition

- Schizophrenia is a chronic and severe mental disorder that affects how an individual thinks, feels, and behaves. Someone with schizophrenia may seem like they have lost touch with reality.
- **Causes:**
  - Imbalance in the complex, interrelated chemical reactions of the brain involving the neurotransmitters dopamine and glutamate.
  - Genetics
  - Problems during brain development before birth may lead to faulty connections. The brain also undergoes major changes during puberty, and these changes could trigger psychotic symptoms in people who are vulnerable due to genetics or brain differences.

National Institute of Mental Health, 2017

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Schizophrenia in later life

- About ¼ of older adults with schizophrenia achieve symptom remission and/or become experts at managing their symptoms.
- "Active symptoms" (e.g., hallucinations, delusions) tend to decrease in later life.
- Negative, harder to notice symptoms (e.g. apathy, anhedonia) tend to persist.
- Depression is common (44 to 75%) for middle-aged and older adults with schizophrenia.
- Impaired cognition is a core feature of schizophrenia however the long-term course of cognition in schizophrenia is unknown.
- Almost all older people with schizophrenia are typically well behind their healthy age peers with respect to social achievements.

Cohen, Meesters, & Zhao, 2015

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Physical Health

- Older adults with schizophrenia tend to have multiple medical problems(Chafetz et al., 2006, Viertio et al., 2009, Cohen et al., 2015) .
- The **cost to care** for this population exceeds that of other common medical and psychiatric disorders (e.g. dementia) (Bartels et al., 2003).
- Age adjusted mortality rates for people with schizophrenia are two times that of the general population and they tend to die 10-25 years earlier than someone without SMI (Parks et al., 2006).
- Very disabled and very expensive population.

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Treatment

- All of the following assist with integration in the community.
- Medications to manage symptoms such as delusions, hallucinations, paranoia.
- Social skills training programs as adjunct treatment of symptoms (e.g., apathy, anhedonia), depression, socialization, and life skills training (cooking, cleaning, etc.).
- Supported employment programs.
- Cognitive training.
- Case management strategies include the improvement of the patient's social and cognitive skills in conjunction with physical health enhancing strategies.

Bartels and Pratt, 2009 & Cohen, Meesters, and Zhao, 2015

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Illness trajectory

- The ideal trajectory for older adults with SMI is a process in which they move from remission (symptomatic recovery) to community integration (functional recovery).

How does this relate to someone leaving prison?

- We need to assess their symptom relief prior to leaving prison and assure they have necessary medications prior to, upon release, and frequently re-check once in the community. **Psychiatrist and transitional case management are key.**
- Work on community integration prior to, upon release, and frequently re-check once in the community. **Housing, Benefits applications, and Support.**
- **Address health needs** prior to, upon release, and frequently re-check once in the community.

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Perspectives of older adults with schizophrenia on successful community living

- Data collection from semi-structured interviews with older adults with schizophrenia conducted during my dissertation work in 2007—2009.
- Data collection from a current study with older adults with SMI.

Leutwyler and Wallhagen, 2010, Leutwyler, Wallhagen, and Chafetz, 2010, and Leutwyler, Fox, and Wallhagen, 2013.

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Design and Sample

- One-on-one interviews and ongoing participant observation
- 28 participants between 55-76 years old recruited from 3 sites
- Average age 61, standard deviation 6 years

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Medications and therapy

- **Freud:** It's minor. It's 15 mg of abilify in the morning. I'm not sure it's helping me, but I don't have any qualms about taking it. It was prescribed. I took it at the suggestion of the [clinic]. And I kept it up in jail, and without fail, and I keep it now – loyally. And I guess it's helping me. **I don't want to give it up, just as a safety precaution**.
- **Earl:** And then when I went to [Hospital], I come out there and they assigned me to a doctor. I had a doctor to talk to, psychiatrist who's started medication for me every month. **But I talked to him — I talked to him once a week, and then he had asked me how the voices are doing, and I'd tell him how the medication is doing. He said do you want to try a different type of medication and I said no.**

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Medications

- **Zach:** It's the medication....**the medication made me feel normal... maybe I can do better things and go bike riding** — well, I can't ride my bike with my leg. But maybe I can like go places, go to Golden Gate Park, and take a walk through Golden Gate Park all the way down to the beach, or something like that…

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Housing

- **John:** I ended up in jail, and I got help by a group called "Homeless —," something, to do with the sheriff's department…One of their programs, and I happened to know the lady there from years before, and she got me a place…and see, I was homeless…I had to go to court, and make courts dates..so I had to stay inside the city. I couldn't go out where I was used to staying when I was homeless, which was out at the beach and stuff. She said I want you to go over here to the homeless outreach team…And they provided me a place to live. It's not too bad. I don't mind… I know it's not the greatest place in the world, you know, but for me right now, I don't mind it at all…I like that, um, I'm pretty much left alone and **nobody bothers me, and I don't bother other people.**

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Housing

- **Suzie:** Yeah, because **I need a therapist for many reasons because I get turned down for housing because of my criminal history**. Well, in order to offset that, I need some letters from a therapist, from a psychiatrist, and from my case manager to take to City Hall in the Mayor's office on housing, or whatever it is, and turn that over, you know? Appeal it. So I need some of these doctors' help.

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Housing and Case Management

- **Malcom**: You know it took me three years of programs and I've never done no more than three months. **It was just an institutional cycle of no change.** And when **(case manager)** supported me —it took me three years of this — of just going through challenges direct through, you know, changes up until the co-op. And when they'd seen I was ready, a lawyer worked with me…with the housing authorities —

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Case Managers and Social Support

- **Malcom**: so I learned that if I'm going to have an issue or a problem, I'll try to have it at home, or **have it here with [case manager] in the center where I'm safe**...It's like, you know, don't get out of hand with it. Don't, you know, if you've got a problem, you need to talk with somebody. We have hotlines now, we have the center, most of all we've got case workers, we've got psychiatrists, and most of all, we have like a peers for one another.

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Case managers

- **Bob**: **case managers tend to be somebody you can talk to.** And if I see something coming, I can be ready.... Like if **you got some other people in your corner that** you can go and say, well, look, I've got this problem right here, and the only solution I see is this... other people's solutions and what they think, you know?

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Community integration and daily skills

- Participants talked about the difficulties they dealt with in **adjusting to living on their own in an apartment after breaking the cycle of going from hospital or incarceration to home and back again**. Difficulties included cooking, cleaning, and managing medications and multiple appointments. This might explain why Joe, who had spent most of his life living in a locked facility, talked about feeling safest and healthiest while living in a locked facility.
- *I'm glad that I do have people here in this hospital who care about me like my [social worker], he cares about me. I get along with the patients perfectly well. I like being in the hospital. (Joe)*

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Community Integration

- **Bob**: I graduated from here (transitional residential facility)…But I kept coming back, because it keeps me **focused. It keeps me looking to see where I'm going, you know, instead of getting off track.** Because sometimes, when you have a mental problem, sometimes if you be by yourself too much, it can be bad. It can be really bad. And then if you get around the wrong people, it can be bad. So, I think, case managers, and places like (residential facility) is definitely what are needed.

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Support, housing, and medications

- **Zach:** I just started feeling suicidal, and just started feeling like I wanted to hit somebody, but I didn't. You know, I controlled it. I told somebody... that's the best thing to do I think. Well, I don't want to hit nobody, because if I hit somebody...I'll go to prison, because I've been to prison three times already. And if I go to prison and hit somebody and get a felony, they'll throw away the key — 24 to life. And I don't want to go back to prison for 24 to life, you know. So I've been out of trouble for — since 1999. I've been off parole for — since 1999...doing real good....I don't want to go to prison, because prison is like — it reminds me of right now of living in a dorm (homeless shelter). You know, all the men together, and it just — I don't have no privacy, no nothing. I couldn't live — I can't live there with a lot of people. You know, it makes me schizophrenic and all this stuff.
- Zach went on to describe the importance of therapy, finding the right medications, and staying on medications.

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Engaged in care

- **Suzie:** Of course they try, but still, the bottom line is that I would like to be included. **I would like somebody to ask me what I need, instead of telling me what I need.**

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Forensic Assertive Community Treatment

- An adaption of an existing evidence-based case management approach with a multi-disciplinary team providing comprehensive support to the person with SMI in an individually tailored way.
  - The model is **time unlimited** thus presupposing the need for ongoing support as well as **fluctuations in chronic psychiatric symptoms** (Angell et al., 2014).
  - Adaptions to meet the needs of individuals leaving the criminal justice system include a focus on preventing incarceration rather than hospitalization and **more direct collaboration with the criminal justice authorities** (Angell et al., 2014).
  - Despite a growing evidence base for models like FACT, guidelines and funding for case management for those with SMI is inadequate in the USA and in many nations around the world, leading to high rates of recidivism and avoidable exacerbation of psychiatric symptoms in this medically vulnerable population.

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Issues to consider for successful community re-entry

- **Warm hand off with community agencies**
- **Transitional Case Management**
  - Benefits applications
- **Medication**
  - Adherence issues while in prison
  - Side effect management
  - Adequate supply upon release
  - Linkage with case management and psychiatrist
- **Housing**
- **Psychiatric Symptoms that are difficult to treat**
  - attention, apathy, anhedonia, disorganized thoughts.
- **Cognitive Decline**

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More factors to work on for successful community re-entry

- **Coordination with community programs**
  - Community agencies not put off by clients with criminal justice history. It is standard. Community agencies want to help.
  - Community agencies need information about the clients they are receiving. The CDCR can help with that link.
- **Psychiatric Advanced Care Directives**
- **Leaders in mental health services and CDCR leadership come together to identify and develop best practices**
  - When was the last time that a meeting happened between community mental health agencies and the CDCR?

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EARL CASE STUDY

•Difficulty obtaining psychiatric care prior to prison

•Self medicating with alcohol, heroin, cocaine

•Incarcerated then transferred to state psychiatric facility

Earl was eventually released from prison and was linked up with a case management program as well as a psychiatrist upon his release. Earl described how he felt, living out in OUR community, with these supports in place:

"Oh, I'm in a beautiful spot…It (case management program) helps get a little more structure in my life. It helps me cope with staying clean and sober so I'm not medicating myself…

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Earl went on to describe the specific role that his case manager plays in his life:

"we talk once a week about anything I want to talk about. And we meet every Friday at 11:00…she tells me what she thinks I should be doing, or I shouldn't be doing. She asks me a lot of questions about how I feel. She's kind of like a psychiatrist.

"I missed a few days. She asked why. I said I feel depressed. She says So when you feel depressed, come here and we'll work through it..

Earl ended our interview with an insight that I believe can be a guide for our care of people with SMI:

every time I go out there, I see somebody talking to themselves…they need to reach out to someone that's going to be understanding, that's going to make them feel real comfortable and cared for, I mean, there's an opening to make a better person out of that person.

Leutwyler, Hubbard, and Zahnd, 2017

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